A COMPARATIVE STUDY TO ASSESS THE QUALITY OF LIFE AMONG CARE GIVERS OF PATIENTS WITH SCHIZOPHRENIA AND MANIA IN SELECTED HOSPITAL AT TIRNELVELI

A DISSERTATION SUBMITTED TO THE TAMIL NADU DR. M.G.R.MEDICAL UNIVERSITY, CHENNAI, IN PARTIAL FULFILLMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

OCTOBER-2016

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APPROVED BY THE DISSERTATION COMMITTEE ON: JULY 2016

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BONAFIDE CERTIFICATE

I hereby declare that the present dissertation titled **"A COMPARATIVE STUDY TO ASSESS THE QUALITY OF LIFE AMONG CARE GIVERS OF PATIENTS WITH SCHIZOPHRENIA AND MANIA IN SELECTED HOSPITAL AT TIRUNELVELI".**is abonafide research work done by **Ms.Krishna Leela.S, M.ScNursing II year** under the guidance of **Mrs.D.SarathaBai William.M.Sc,(N).,MBA (HM).,** HOD of psychiatric Nursing,partial fulfillment for the Degree of Master of Science in Nursing, under The Tamil Nadu Dr.M.G.R. Medical University, Chennai.

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This is to certify that the dissertation entitled **"A COMPARATIVE STUDY TO ASSESS THE QUALITY OF LIFE AMONG CARE GIVERS OF PATIENTS WITH SCHIZOPHRENIA AND MANIA IN SELECTED HOSPITAL AT TIRUNELVELI".** is a bonafide research work done by **Ms.Krishna Leela.S,M.Sc Nursing II year** Nehru Nursing College, Vallioor, in the partial fulfillment for the degree of Master of Science in Nursing under the Tamil Nadu Dr.M.G.R.Medical University, Chennai.

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DECLARATION

I hereby declare that the present dissertation titled **"A COMPARATIVE STUDY TO ASSESS THE QUALITY OF LIFE AMONG CARE GIVERS OF PATIENTS WITH SCHIZOPHRENIA AND MANIA IN SELECTED HOSPITAL AT TIRNELVELI".**is the outcome of the original research work undertaken and carried out by me, under the guidance of **Mrs.D.Saratha Bai William,M.Sc.(N).,MBA(HM).,** H.O.D of Psychiatric Nursing. Nehru Nursing College,Vallioor. I also declare that the material of this has not formed in any way, the basis for the award of any degree or diploma in this university or any other universities.

Place :Vallioor **Ms. Krishna Leela.S,**

Date : **M.Sc (N) II year.**

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ACKNOWLEDGMENT

"Humble Yourself In The Sight Of the Lord, and He will lift You Up"

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Investigator

ABSTRACT

The present dissertation was under taken **"A comparative study to assess the quality of life among care givers of patients with schizophrenia and mania in selected hospital at Tirunelveli".**

OBJECTIVES:-

- To assess the quality of life among care givers of patients with schizophrenia.
- To assess the quality of life among care givers of patients with mania.
- To compare the quality of life among care givers of patients with schizophrenia and mania.
- To find association between quality of life among care givers of patients with selected demographic and clinical variables.

HYPOTHESES :-

The hypothesis formulated for the present study are:

H_1: There is significant association between the Quality Of Life among care givers of patients with schizophrenia and mania in their selected demographic and clinical variables.

Non experimental Descriptive Comparative design was adopted for this study. The conceptual framework for this study was based on Modified Wilson and Cleary Model(1995).The tool used for data collection was Modified WHO Adult Quality of life of care givers assessment scale to assess the Quality of life

Schizophrenia patients care givers and Mania patients care givers. The sample size of the study was selected purposively. Sample size of the study was 50 among which 25 samples were in Schizophrenia patients care givers and 25 samples were in Mania patients care givers.

Major findings of the study:

The mean and standard deviation score of quality of life of care givers of patient with Schizophrenia was 46.68± 12.03. The mean and standard deviation score of quality of life of care givers of patient with Mania was 60.08± 12.28. The mean difference was 13.40 and it was inferred that the quality of life of schizophrenia care givers was low comparing to mania care givers.

There is no significant association between selected demographic variables life age, gender, religion, education, occupation, type of family, monthly income, marital status, relationship of the patient, residency and their Quality of life. There is no significant association between selected clinical variables like Duration of illness, No of hospitalization, Type of admission, Availability of support system and their Quality of life.

Conclusion:

The main conclusion drawn from this present study was that the quality of life among schizophrenia care givers was low comparing to the mania care givers. As the stress level of schizophrenia patients care givers were high, the researcher provided Counseling distributed and the pamphlets regarding stress management technique to relieve their stress level and improve their quality of life.

CHAPTER -I

"We are what we think. All that we are arise with our thoughts

With our thoughts we make the world"

- Gautama Buddha

INTRODUCTION

Happiness is a term which usually defines the life satisfaction. If unpleasant things are happening than pleasant things the persons will be dissatisfied and put themselves into unhappy. The important factor which contributes to happiness is "Good Health". **(Elizabeth Hurlock,2002)**.

Mental health is the successful performance of mental functions, resulting in the ability to engage in the productive activities, fulfillment of relationship, and change or cope with the adversity. Mental health provides the capacity for rational thinking, communication skills, learning, emotional growth, resilience and esteem. However it excludes normal responses such as grief from loss of a loved one, and also excludes deviant behavior for political, religious, or societal reasons not arising from a dysfunction in the individual.

Mental illness can be defined as a clinical, significant, behavioral or psychological syndrome that occurs in a person and this is normally associated

with impairment in one or more important areas in functioning, or an important loss of freedom. ***Townsend (2003)***

Most of the mental illness is associated with a major change in the behavioral pattern of the client and these changes may affect the patient and family in different degrees. Most of the mental illness does not have a single cause in common and it is generally associated with a structural change in the brain.

Schizophrenia is one of the major mental disorders characterized by abnormalities in the perception or expression of reality. Onset of symptoms typically occurs in young adulthood. Even with available treatments most people with schizophrenia continue to experience symptom hospital to families and on society at large in terms of significant direct and indirect costs that include frequent hospitalizations and the need for long term psychosocial and economic support as well as life time lost productivity throughout their lives. This will creates profound burden in the lives of their family members.

Mania is a state of abnormally elevated arousal, affect, and energy level, or "a state of heightened overall activation with enhanced affective expression together with liability of affect." Although mania is often conceived as a “mirror image” to depression, the heightened mood can be either euphoric or irritable; indeed, as the mania intensifies, irritability may become more pronounced and eventuate in violence.

The symptoms of mania are the following: heightened mood (either euphoric or irritable); flight of ideas and pressure of speech; and increased energy, decreased need for sleep, and hyperactivity. They are most plainly evident in fully developed hypomanic states; in full-blown mania, however, they undergo progressively severe exacerbations and become more and more obscured by other signs and symptoms, such as delusions and fragmentation of behavior. mania is a syndrome of multiple causes. Although the vast majority of cases occur in the context of bipolar disorder, it is a key component of other psychiatric disorders and may also occur secondary to various general medical conditions, as multiple sclerosis; certain medications, as prednisone; or certain substances of abuse, as cocaine or anabolic steroids. In current DSM-5 nomenclature, hypomanic episodes are separated from the more severe full manic episodes, which, in turn, are characterized as either mild, moderate, or severe, with specifies with regard to certain symptomatic features. mania, however, may be divided into three stages: hypomania, or stage I acute mania, or stage II; and delirious mania, or stage III. This "staging" of a manic episode is, in particular, very useful from a descriptive and differential diagnostic point of view.

Mania should be diagnosed early to improve compliance with the treatment. Those who never experience depression also experience cyclical changes in mood. These cycles are often affected by changes in sleep cycle (too much or too little), and environmental stressors.

Mental health problem in India mostly remains unnoticed due to various reasons i.e. either not considered as a problem needing attention or some times it

is ignored as no one in the issue of mental ailment. The situation gets further aggravated by lack of adequate medical ailment. The situation gets further aggravated by lack of adequate or health facility to treat the case right earnest.

According to WHO "Quality of Life is defined as individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns. It is broad ranging concept, incorporating a complex way of independence, social relationships, personal beliefs, and their relationships to salient features of the environment. This definition high lights the view that quality of life and is multi-dimensional. Lehman also stated quality of life of care givers perspectives on what they have, how they are doing, and how they feel about their circumstances".

Care givers was observed quite commonly among the patients of mental disorder i.e. mania and schizophrenia visiting to Institute of Human Behavior and Allied Sciences (IHBAS) Delhi. The study was carried out by a team of psychiatrist, social and behavioral scientist to look into various qualitative dimensions of quality of life of care givers and their way of dealing with patients.

The presence of a mentally ill patient in a family cause stressful experience to the care givers especially in physical, emotional, social and financial areas. More the patient behavior and functional disability put the primary care givers in a great risk as the care giving to a mentally ill patient is a very complex process as most of the mentally illness occur with a change in the behavioral pattern of the patient .These factors may act as a burden to the care givers and can affect even

the quality of life of the primary care giver too; as a health professional the mental health nurse has a main responsibility in identifying these levels of burden, coping and quality of life among the care givers specially the primary care givers of the mentally ill patients

NEED FOR THE STUDY

Mental illness is the maladjustment in living. It produces disharmony in the person's ability to meet human needs comfortably or effectively and function within culture. Because of the disharmony in meeting needs the quality of life of the ill people get worsen. Recently health- related quality of life (QOL) has been regarded as the most important dimension of outcome in schizophrenia and other serious mental disorders. This study is concerned about assessing the quality of life of schizophrenia caregivers. There are so many studies are done to assess the quality of life of the schizophrenia and mania patients care givers.

Quality of life can be indicated through different factors. Living situation, marital status, employment status, and involvement in social activities all these are some of the factors affecting quality of life. Although psychiatric symptoms reduction alone often does not result in meaningful improvements in quality of life. The results of data analysis suggest that general psychopathology is the strongest contributor to quality of life.

Little is known about the burden of care and ways in which families cope while caring for a relative with schizophrenia in a developing country. In India the

prevalence of schizophrenia is 3 in 1000 population. This study aims to look at the burden of care and different coping style used by family members to cope with patient with schizophrenia and to identify the factors correlate with the burden and coping style.

Worldwide, the prevalence of mania disorder type I is estimated to be 0.6%, that of type II is 0.4%, and that of sub threshold mania disorder is 1.4%, yielding a total mania disorder spectrum prevalence of 2.4%.In general, high-income countries have the highest prevalence of bipolar disease and low-income countries have the lowest. The United States had the highest prevalence of overall (4.4%) and annual (2.8%) disease, while India had the lowest (0.1% for both). Two exceptions to this rule were Japan, a high-income country with very low overall (0.7%) and annual (0.2%) prevalence, and Colombia, a low-income country with a high overall prevalence (2.6%).

According to a survey by (Reddy, 1998) the prevalence estimate rate of mental illness in India is 58.2/1000 population. Now a more recent study of mental disorder in India conducted and concluded that the prevalence rate of a mental disorders in India is 73/1000 that is in Rural 70.5and in Urban73.0 out of 1000.

A study was conducted by (WHO in 2003) concluded that there are about 40 million mentally ill persons in India. A study conducted on household income and quality of life of primary care givers of persons with mental illness in China showed the burden of the primary care givers positively correlate with

household income which means the economic status, occupation and perceived external support can act directly on quality of life. As now our country giving much importance for decentralization of mentally ill patients to community based care, there is a strong need to access how they cope with stress even without professional support.

26 mentally ill patients were charred to death, caused a wide spread sense of shock and anger as it was reported that the patients were apparently kept chained at Religious Shelter and Rehabilitation Centers. It is due to the fact that the family members caring for mentally ill, have perceived it as a burden, so they institutionalize the patient which affects the patients quality of life. **(ERWADY)**

Each year, one in 10,000 people age 12 to 60 develops schizophrenia. It is diagnosed 1.4 times more frequently in males than females and typically appears earlier in men the peak ages of onset are 10-28 years for females. Onset in childhood is much rare as is onset in middle or old age. Prevalence rates for all mental disorders was observed to be 65.4 per 1000 population. prevalence rates for schizophrenia, affective disorders, Anxiety neurosis, hysteria and mental retardation were 2.3, 31.1, 18.5, 4.1 and 4.2 per 1000 population respectively. The urban morbidity rate was 2 per1000 higher than the rural rate.

A study conducted in London to evaluate the quality of life of patients with psychotic disorders showed that informal caregivers experience negative changes in their quality of life and it also revealed that physical, emotional and economic distress affect negatively care givers quality of life as a result of a

number of unfulfilled needs such as, restoration of patient functioning in family and social roles, economic burden, lack of spare time.

Several other studies showed that there will be a lot of burden and decreased coping among the family members of the mentally ill patients including an alteration in the quality of their life also. So this initiated the Nursing Researcher to conduct a study to assess the quality of life among care givers of patient with schizophrenia and mania. This study will provide future benefit in developing an intervention to improve the coping methods and quality of life of the care givers of the schizophrenia and mania.

Schizophrenia is a major illness that has a tremendous impact on individual and family life Research findings shows that the quality of life among patients with schizophrenia is scarce in India **(Lobana et al.,2002**).The growing recognition that a large proportion of persons with schizophrenia experience long term disability symptoms are adequately controlled by medication had led to the development of the field of psychiatric rehabilitation which aims to optimize the recovery of individuals with schizophrenia. Individual with this disorder becomes either totally or partially dependent on the care givers.

Chan and YU (2004) conducted a study on quality of life among care givers in mania at Hong Kong on general population. Stigma, unemployed and poverty have a great impact on care givers quality of life and lower score for the perceived quality of life. Family support plays a great value on clients satisfaction with social support. Quality of life takes accounts of improvements in function or

distress that fall short of complete cure. All these incidents and disturbance affect the patients life in different way and life of care givers.

STATEMENT OF THE PROBLEM

"A comparative study to assess the quality of life among care givers of patients with schizophrenia and mania in selected hospital at Tirunelveli"

OBJECTIVES

- To assess the quality of life among care givers of patients with schizophrenia.
- To assess the quality of life among care givers of patients with mania.
- To compare the quality of life among care givers of patients with schizophrenia and mania.
- To find association between quality of life among care givers of patients with selected demographic and clinical variables.

HYPOTHESES:

The hypothesis formulated for the present study are:

H_1: There is significant association between the Quality of Life among care givers of patients with schizophrenia and mania with their selected demographic and clinical variables.

OPERATIONAL DEFINITION

QUALITY OF LIFE

Quality of life is a person's sense of wellbeing and satisfaction with his or her life circumstances as well as a person's health status assessed with Modified Adult Quality of Life care givers assessment scale.

CARE GIVERS

A person who was involved in direct care of mentally ill patient an spent most of their time for caring the patient. This is usually the family member. Who may be (Father, Mother, Husband, Wife, Brother, Sister) Who are providing care for the mentally ill patients.

PATIENTS WITH SCHIZOPHRENIA

The patients who are diagnosed and having associated symptoms of schizophrenia atleast one year of duration.

PATIENTS WITH MANIA

The patients who are diagnosed and having associated symptoms of mania for atleast one year of duration.

ASSUMPTIONS

- Quality of life of care givers may be altered due to mentally ill patients.
- Quality of life is difference for different individuals.

DELIMITATIONS

- This study is delimited to self report method of data collection with structured questionnaire.
- This study is delimited to four weeks of data collection

CONCEPTUAL FRAMEWORK

The researcher adopted health related quality of life model by **Modified Wilson and Cleary.** Wilson and Cleary published their conceptual model of quality of life in 1995 and it was later revised by **Ferris et al**. Proposed a conceptual model of life (HRQOL) that integrated both biological and psychological aspects of health outcomes. There are five different levels in their model. Namely physiological factors, symptom status functional health, general health perceptions and overall quality of life.

Physiological factors:

In this study the physiological factors like collected two way that is demographic variables and clinical variables were collected. In Demographic variables included Age, Gender, Religion, Education, Occupation, Type of the

family, Monthly income, Marital status, Relationship of the patient, Residency were included Under Clinical variables included Duration of the illness, Number of the hospitalization, Type of admission, Availability of support system were included.

Symptoms status:

In this study symptoms status divided into two schizophrenia care givers and mania care givers.

Functional status:

In this study quality of life was assessed by Modified WHO Adult quality of life care givers assessment scale.

Overall quality of life:

In this study the quality of life among schizophrenia care givers was low quality of life comparing to a mania care givers.

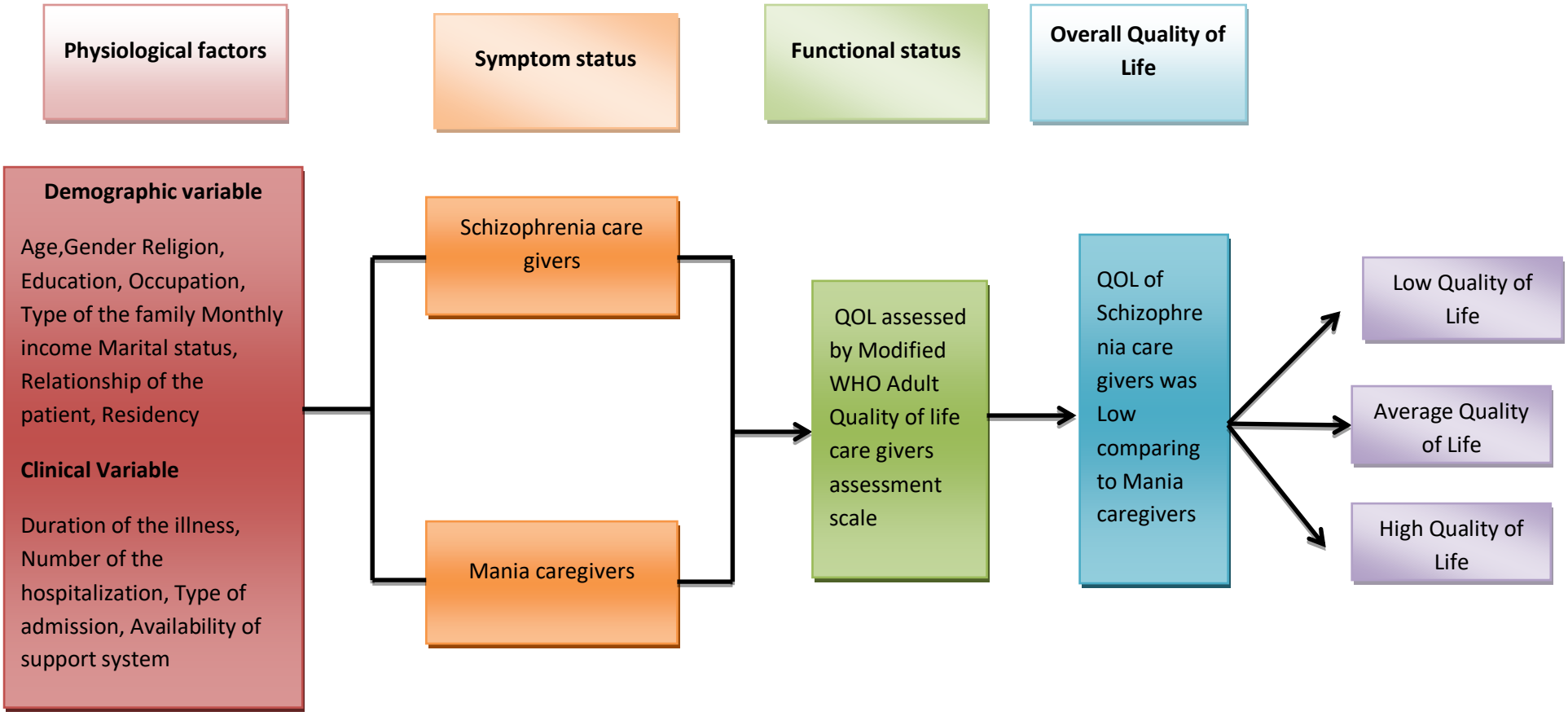

Fig 1: MODIFIED CONCEPTUAL FRAMEWORK OF HEALTH RELATED QUALITY OF LIFE BY WILSON AND CLEARY (1995)

CHAPTER – II

REVIEW OF LITERATURE

A literature review is a crucial early task for quantitative studies which helps to shape the research questions, contribute to the argument about the need for a new study, and suggest appropriate methods and points to a conceptual or theoretical framework **(Polit, 2009).**

The review of literature was done from published articles, text book, and report and medline search.

The literature review has been organized under the following headings.

1. Review related to Quality of life of care givers of mentally ill patients.
2. Review related to Quality of life of care givers of patients with schizophrenia and mania.

1. REVIEW RELATED TO QUALITY OF LIFE OF CARE GIVERS OF MENTALLY ILL PATIENTS

Gelder,M. (2009) Conducted a study done in Madison to examine the relation between caregivers mental health and quality of life and stigma. Interviews were conducted among 85 Latinos caregivers. Data were collected by

using measures such as the Zarit quality of life Scale, and the Greenley Stigma Scale. 40% of samples were having low quality of life. Younger care givers age, lower levels of care givers education, and higher levels of the patients mental illness symptoms were predictive of higher levels of care givers depressive symptoms. Care givers quality of life mediated the relation between patients psychiatric symptoms and care givers depression. Care givers perceived stigma was significantly related to care givers low quality of life.

Fazal,S. (2009) conducted a Study on quality of life of the relatives of schizophrenic patients was done in India. The sample comprised of 44 patients with schizophrenia and 44 relatives from an outpatient psychiatric clinic were assessed. Resignation, an emotional focused strategy, was found to be more commonly employed by the relatives. Majority of the relatives failed to maintain social contacts. Analysis of the level of quality of life of the relatives is essential before clinical interventions with families are planned to improve the level of quality of life of the caregivers.

Christine,E.(2009) conducted a study on subjective relation between the age and quality of life among primary care givers of people with mental illness in South-Western Nigeria. The study was conducted among 100 adult care givers of mentally ill patients. The aim of the study was to examine the rate the association of quality of life with the age of the care givers, the result of the study concluded that rather than age of the care givers the perceived health status of the care givers act as a negative factor for development of low quality of life. Care givers

should be encouraged to meet regularly to share their experiences and ventilate their emotions.

Bob Van (2005) conducted a study on quality of life to assess the 'Quality of life of primary care givers on providing care to a mentally ill person was conducted in Taiwan. The Researcher collected subjective &objective information using observation, face-face interviews, and care givers quality of life. The tool used was Taiwanese quality of life scale. The result shows that the care givers face low quality of life.

Alison (2005) conducted a study to find out the importance of supportive groups in improving the quality of life of the primary care givers of the mentally ill patients. A cross-sectional study was carried out and a total of 404 care givers participated in the study, the result of the study concluded that the supportive groups and their psycho-educative orientation programs like exchange of experience, open discussion, information's and advices play a major role in coping with the induced burden in caring a mentally ill patient.

Willms,H. (2004) conducted a study on Quality of life (QOL) of care givers of patients with a selected mental illness. A total of 60 care givers participated in the study. The result evidence suggest that physical, emotional and economic distress, negatively affect care givers as a result of a number of unfulfilled needs such as restoration of patient roles (in family and social), Economic burden. Lack of spare time to spend with the family and friends.

Bista,Y. Rawal,N.(2002) conducted a study in Canada to find the factors associated with quality of life of primary care givers of patients with cerebral palsy. A total of 468 care givers participated in the study. Data on demographic variables and primary care givers psychological health were assessed by using standardized questionnaires as well as face to face interview. The result of the study revealed that the factors such as, gross income, social support, and self perception of the existing condition of the patients act as an important role in improving the quality of life.

Nasr,T and Kausar, R.(2000) conducted a study on "Psycho education and the quality of life in schizophrenia". A total of 108 patients with schizophrenia and their family members from the outpatient department of a teaching hospital in Lahore, Pakistan. Both groups received psychotropic drugs but one group received psycho education in addition. Quality of life was assessed at the time of recruitment and at 6 month post intervention. In all, 99 patients and their relatives completed the treatment. There was significant increase in quality of life at post-intervention assessment in the psycho education group based on intention to treat analysis.

2. REVIEW RELATED TO QUALITY OF LIFE OF CARE GIVERS OF PATIENT WITH SCHIZOPHRENIA AND MANIA

Pratima (2015) conducted a study among family care givers of persons with mania disorders and schizophrenia experience high level of burden and compromised quality of life. A considerable amount of burden on the caregivers

often leads to display of certain attitudes towards persons with severe mental illness called expressed emotion, which then leads to poor quality of patients as well. The aim of the present study was to understand how actually the construct of quality of life in different demographic conditions affect life conditions of schizophrenic and mania patients and determining relapse. The present study was designed mainly to assess the quality of life on patients and the families of a particular group of patients namely those with schizophrenia and mania. The quality of life of patients with schizophrenia and mania were low. The quality of life of care givers of patients with schizophrenia (64%)had high quality of life comparing to caregivers of patients with mania affective disorder. The 't'value 7.84 was significance at 0.05 level of probability. The stress from the remarks and attitudes of the family was overwhelming because they feel like the cause of the problems. The patient then falls into the cycle of relapse. The only way to escape this vortex for the family was to go through therapy together to prevent the relapse. But before that it becomes necessary to understand that what is the reason behind such attitude towards a family member who is mentally ill, what is the cause of burden and what all changes the caregivers' and the patients quality of life come across.

Federick (2010) conducted a comparative study on relatives of long term psychiatric patients (schizophrenia and mania) assessed the quality of life among caregivers. Data were collected by using Burden assessment schedule [BAS]in 100 patients with 50 caregivers of mania and 50 care givers of schizophrenia. When the two groups were compared, among the care givers of schizophrenia patients 26 had low level of Quality of life, 13 had average level of Quality of life

and 11 had high level of Quality of life. Among the care givers of mania patients 12 had low level of Quality of life, 17 had average level of Quality of life and 21 had high level of Quality of life. Results showed that care givers of schizophrenia patients should low quality of life as compared to mania patients.

Roe,k.(2009) conducted a study in Institute of Mental Health, Agra to measure the Quality of life by caregivers of patients with schizophrenia and mania. The samples were care givers of 34 patients. The quality of life among the care givers were assessed by Burden assessment schedule [BAS].There was a low positive correlation between age less than 30 years and the physical and mental health of the care givers, and with taking responsibility. The t-test (5.86) for population correlation was significant up to 5% probability level ($P< 0.05$) for correlation between urban domicile and support of the patient.

Krumm,S. (2009) Conducted a comparative study was done in India to assess the extent and pattern of family quality of life in mania and schizophrenia. Data were collected by using Pai and Kapur's Interview schedule in 100 patients with 50 mania and 50 patients with schizophrenia. The extent of objective and subjective quality of life was significantly more in relatives of schizophrenics and the maximum low quality of life was seen in the routine family activities. When the two groups were compared it, among the care givers of schizophrenia patients 30 had low level of Quality of life13 had average had of Quality of life and 12 had high level of Quality of life was shown that the schizophrenic group had significantly more low quality of life, disruption of family routine and disruption of family leisure.

Magitha (2008) conducted a study to assess the quality of life of care givers of person with schizophrenia and mania was done in NIMHANS, Bangalore. The sample comprised of 24 parents and 24 spouses. Patients were

assessed on Global Assessment Scale (GAS) and care givers were assessed on Quality of life Assessment schedule (BAS) and the Coping Checklist (CCL). Mean total low quality of life experienced by the spouses (70%) is more than the parents (65.4%). Spouses reported greater poor quality of life (17.88). Parents used more of denial as a coping strategy, while spouses more of negative distraction strategies. Patients age, educational level, care givers use of denial as a coping strategy emerged as significant predictors of care givers burden. The study highlights the fact that family intervention programs need to address the specific concerns of care givers.

Senbagam (2007) conducted a cross sectional study was conducted in Sweden to find out the quality of life faced by the primary care givers of mentally ill patients. In Sweden total of 100 primary care givers of mentally ill persons were assessed using questionnaire by using care givers quality of life assessment scale, the nottingham health scale and since of coherence scale. The results of the study shows that more than 80% of the primary care givers of mentally ill patients are experiencing a low level of quality of life with a standard deviation of 58.69 and the mean difference was statistically high and significant associated with emotional disturbance, a perceived health changes, isolation and disappointment in relation to caring the patient.

Kaplan (2007) conducted a study in Thailand to understand the Quality of life care givers of persons affected with schizophrenia and mania. 120 Primary care givers participated in the study. Quality of life of care givers was analyzed by using Quality of life index generic version. Analysis done by using mean, percentage & standard deviation. The result showed that most of the primary care givers (66%) had moderate level of Quality of life in relation to mania and their health status and perceived social support what they getting from the society.

Shen, Yu-wen et.al (2006) conducted a study on "comparison quality of life between family caregivers of schizophrenia and mania". Data was collected on 60 findings revealed that the care givers of both long term illness like schizophrenia experience low level of quality of life in the areas of patients care, family relations and occupation respectively. A similar pattern has been reported that the most common problems faced by the relatives while caring for the patient are embarrassing and difficult behavior.

Awadalla et al., (2005) conducted a study assessed subjective quality of life of caregivers of schizophrenia, affective disorder and neurosis using WHOQOL- BREF. schizophrenia care givers had lower scores than others. Care givers socio- demographic variables were significantly associated with quality of life. Their quality of life was predicted by their impression of patients and state of health. Spouses of people with mental disorder experience various forms of objective and subjective burden. This should negatively affect their quality of life.

CHAPTER – III

RESEARCH METHODOLOGY

This chapter deals with the methodology adopted by the researcher for the study includes research approach, research design, variables, the setting of the study, population, sample, sample size, sampling technique, development and description of the tool, validity, reliability, pilot study, data collection procedure, plan for data analysis and protection of human rights.

Research approach

Quantitative research approach was used in this study.

Study design

In this study the researcher selected Non Experimental Descriptive Comparative design.

Variable

Quality of life of care givers.

Setting of the study

The subjects were selected from sneka mind care centre, Tirunelveli which is 30 km away from Nehru Nursing College, Vallioor. The hospital is 50 bedded

hospital. Around 120 patients were coming to the out patient department and around 45 patients were admitted in the hospital.

Population

Target population

Care givers of schizophrenia and mania patients.

Accessible population

Care givers of schizophrenia and mania patients in sneka mind care centre, Tirunelveli.

Sample

The study population consists of care givers who fulfilled the inclusion criteria.

Sample size

A sample size comprised of 25 care givers of schizophrenia patients and 25 care givers of mania patients.

Sampling technique

In this study purposive sampling technique was adopted.

Criteria for sample selection

Inclusion criteria:

- Those who are giving care to schizophrenia and mania patients atleast one year of duration.
- Those who are able to understand Tamil.
- Care givers in the age group of 30 – 60Years.

Exclusion criteria

- Primary care givers of mentally ill patients with any type of substance abuse.
- Care givers of patients with any other associated mental illness.

Research tool and technique

The instrument consists of two sections.

Section - A

Demographic variable proforma consists of age, gender, religion, education, occupation, type of family, monthly income, marital status, relationship of the patient and residency. The clinical variable includes duration of illness, number of hospitalization, types of admission and availability of support system.

Section - B

Modified WHO Adult quality of life of care givers Assessment scale

Observing the Quality of Life of Assessment scale Scoring procedure.

Scoring procedure

The assessment scale was a 4 point rating scale which had total of 22 items. The level of quality of life from 22- 44 indicate low quality of life, the level of quality of life from 45- 66 indicate average quality of life and the level of quality of life from 67- 88 indicate high quality of life.

Scoring Key

Modified WHO Adult quality of life of care givers assessment scale

S.NO.	QUALITY OF LIFE	QUALITY OF LIFE SCORE
1.	Low level	The score 22–44
2.	Average level	The score 45 – 66
3.	High level	The score 67–88

Validity

The content validity of the tool was established on the opinion of one expert in the field of Psychiatry and Five Mental Health Nursing experts. The tool was modified as per the consensus of all the experts and the tool was finalized.

Reliability

The reliability score for Modified WHO Adult quality of life of care givers assessment scale was r =0.7 it was determined by test re test method.

Pilot study

The pilot study was a trial run for the major study. The tool was used for the pilot study to test the feasibility and practicability. The pilot study was conducted in sneka mind care centre, Tirunelveli. A formal permission was obtained from the Chairman of sneka mind care centre. The period limited for pilot study was one week.

The researcher introduced herself to the subjects and established rapport with the subjects. 10 samples were selected for the pilot study by using purposive sampling technique. Data pertaining to demographic and clinical variables were collected by structured questionnaire. Researcher assessed 5 schizophrenia patients care givers and 5 mania patients care givers, care givers were able to understand each item and gave appropriate response which was recorded.

Data collection procedure

After obtaining ethical clearance from the research committee, the hospital was selected. Prior permission was obtained from chairman of sneka mind care centre. Purposive sampling technique was used to select the samples. The researcher introduced herself to the subjects and established rapport with the subjects.

Data pertaining to demographic and clinical variables were collected by structured self administered questionnaire. Researcher assessed 25 schizophrenia patients care givers, and 25 mania patients care givers, Modified WHO Adult quality of life of care givers questionnaire items were told to the care givers and responses given were recorded by the researcher.

PLAN FOR DATA ANALYSIS

Descriptive Statistics

- The frequency and percentage distribution of demographic and clinical variables.
- Mean and standard deviation was used to assess the quality of life of care givers of patients with schizophrenia and mania.

Inferential Statistics

Chi-square was used to associate the quality of life of care givers of patients with schizophrenia and mania with their selected demographic and clinical variables

Ethical Consideration

The proposed study was conducted after the approval of the research committee of college. Permission was obtained from the sneka mind care centre. The informed consent of each individual was obtained before data collection. Assurance was given to the study participants regarding the confidentiality of the data collected.

CHAPTER - IV

ANALYSIS AND INTERPRETATION

This chapter deals with analysis and interpretation of the data collected from 50 care givers in selected hospital related to their Quality of life with patients of schizophrenia and mania.

Polit and Hunger (1999) state that statistical analysis is a method of rendering quantitative information in a meaningful and intelligible manner. Statistical procedure enables the researcher to organize, analyze, evaluate, interpret and communicate numerical information meaningful.

The purpose of analysis was to reduce the collected data to an intelligible and interpretable form, so that the relation of research problem can be studied and tested. The results were computed by using descriptive and inferential statistics.

The study findings are presented in sections as follows

Section A: Data related to demographic and clinical variables of sample subjects.

Section B: Data related to Quality of Life of care givers of patients.

Section C: Data related to association of Quality of Life with demographic and clinical variables of sample subjects.

SECTION- A

Table 1: Data on Frequency and percentage distribution of demographic variables among care givers of schizophrenia and mania patients.

S.No	Demographic Variables	Schizophrenia (n=25)		Mania (n=25)	
		f	%	f	%
1	Age (in years)				
	a)30 – 40 years	7	28	6	24
	b)41 – 50 years	7	28	8	32
	c) 51 – 60 years	11	44	11	44
2	Gender				
	a) Male	10	40	12	48
	b)Female	15	60	13	52
3	Religion				
	a)Hindu	13	52	12	48
	b)Christian	8	32	7	28
	c) Muslim	4	16	6	24
	d) Others	0	0	0	0

4	Education				
	a) Illiterate	5	20	4	16
	b) Only school education	8	32	9	36
	c) Diploma/ Degree	7	28	7	28
	d) Professional education	5	20	5	20
5	Occupation				
	a) Un employment	10	40	9	36
	b) Private Company	7	28	6	24
	c) Government Office	3	12	4	16
	d) Business	5	20	6	24
6	Type of family				
	a) Nuclear	18	72	17	68
	b) Joint	7	28	8	32
7	Monthly Income				
	a) UptoRs. 5000	10	40	10	40
	b) Rs. 5001– 10,000	11	44	10	40
	c) Above Rs. 10,000	4	16	5	20
8	Marital Status				
	a) Single	6	24	7	28
	b) Married	12	48	12	48
	c) Widow	4	16	4	16
	d) Separated	3	12	2	8
9	Relationship of the patient				
	a) Parents	5	20	4	16
	b) Spouse	5	20	5	20
	c) Children	9	36	9	36
	d) Siblings	6	24	7	28

10	Residency a) Urban b) Rural	 12 13	 48 52	 11 14	 44 56

Table 1: Among the care givers of25 schizophrenia patients,11(44%) Belong to age group 51-60years,15(60%) were females,13(52%) were Hindus, 8(32%) had only school education,10(40%) Unemployment,18(72%) were Nuclear family, 11(44%) Income was Rs.5001-10,000,12(48%) were Married,9(36%) were Children, 13(52%) living in rural area.

Among the care givers of 25 mania patients,11(44%) Belong to age group 51-60 Years, 13(52%) were females, 12(48%) were Hindus,9(36%)had only school education, 9(36%) Unemloyment,17(68%)were Nuclear family, 10(40%) And 10(40%) Income wasUptoRs.5000 andRs.5001-10.000, 12(48%) were Married,9(36%) were Children, 14(56%) living in rural area.

Table 2: Data on Frequency and percentage distribution of clinical variables among schizophrenia and mania patients.

n=25+25

S.No	Clinical Variables	Schizophrenia		Mania	
		f	%	F	%
1	Duration of illness				
	a) 1 year	5	20	6	24
	b) 1 – 3 years	13	52	11	44
	c) Above 3 years	7	28	8	32
2	Number of hospitalization				
	a) First time	5	20	6	24
	b) Second time	10	40	10	40
	c) More than three times	10	40	9	36
3	Type of admission				
	a) Voluntary admission	13	52	14	56
	b) Involuntary admission	12	48	11	44
4	Availability of support system				
	a) Family				
	b) Friends	16	64	15	60
	c) Society	6	24	7	28
		3	12	3	12

Table 2: Among the care givers of 25 schizophrenia patients,13(52%) had illness for 1-3Years, 10(40%) and were hospitalized for Second time and 10(40%) were hospitalized for more than three times, 13(52%) were admitted voluntarily,16(64%) samples support system was family.

Among the care givers of 25 mania patients,11(44%) had illness for1-3Years, 10(40%) were hospitalized for Second time, 14(56%) were admitted Voluntary,15(60%) samples support system was family.

SECTION-B

Table 3: Data on Frequency and Percentage distribution of level of Quality of Life among care givers of patients with schizophrenia and mania

S.No	Level of Quality of Life	Care givers of patients with Schizophrenia (n = 25)		Care givers of patients with Mania (n = 25)	
		F	%	F	%
1	Low	10	40.00	2	8.00
2	Average	13	52.00	15	60.00
3	High	2	8.00	8	32.00

Table 3: shows that in Care givers of schizophrenia patients, the level of Quality of Life was as follows, 10 (40%) had low level of Quality of Life, 13 (52%) had average level of Quality of Life and 2 (8%) had high level of Quality of Life.

Among care givers of mania patients the level of Quality of Life was as follows, 2 (8%) had low level of Quality of Life was as follows, 15 (60%) had average level of Quality of Life and 8 (32%) had high level of Quality of Life.

Among the care givers of schizophrenia patients 40% belonged to low level of quality of life compared with care givers of mania patients which was only 8%.

With regard to high level of quality of life, only 8% of care givers of schizophrenia patients belonged to high level, where as 32% of care givers of mania patients belonged to high level group. Hence it was inferred that quality of life among care givers of mania patients was higher compared to care givers of schizophrenia patients.

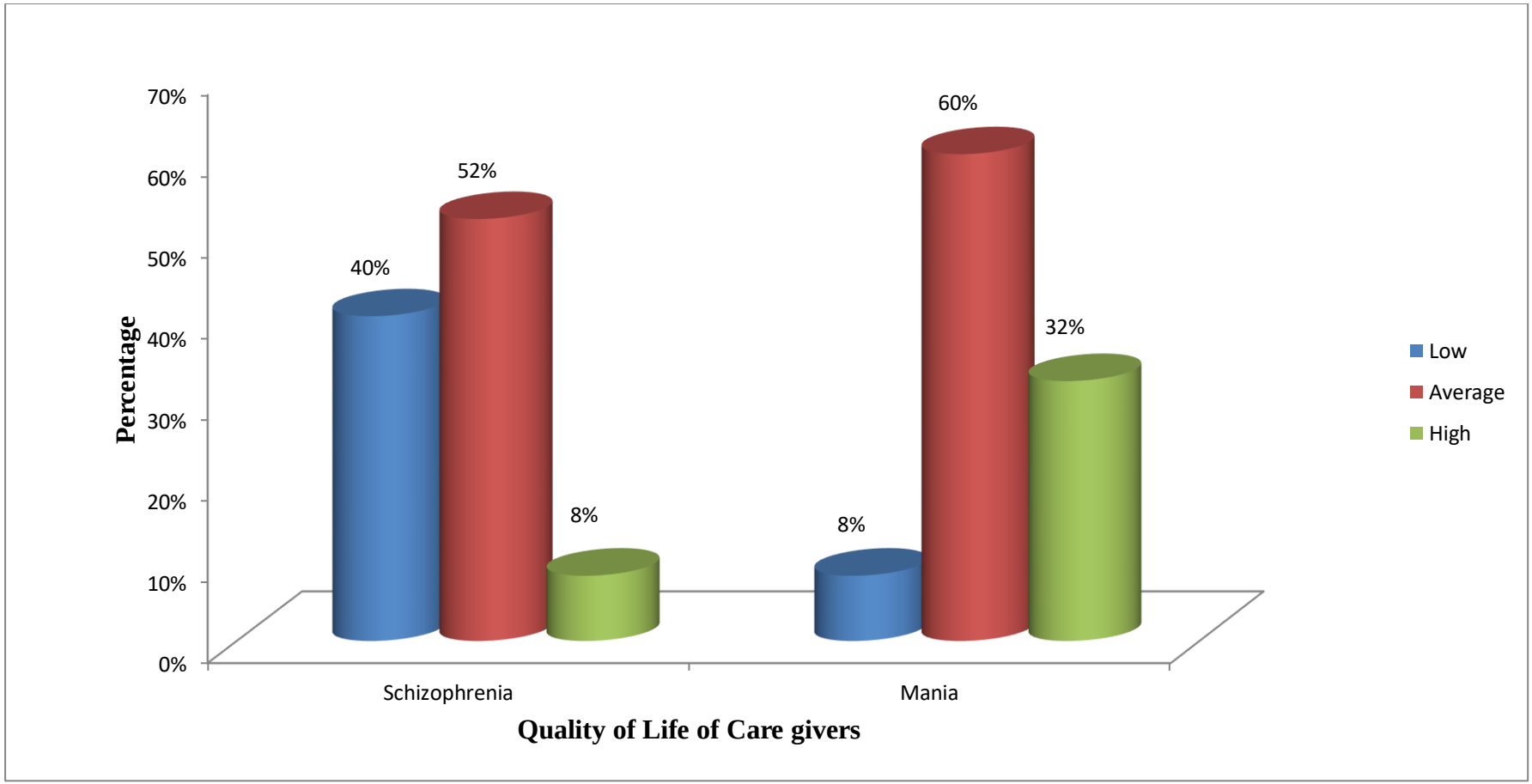

Fig 2: Frequency and Percentage distribution of level of Quality of Life among care givers of patients with schizophrenia and mania

Table 4: Data on comparison of Quality of Life Among care givers of patients with schizophrenia and mania

n = 25+25

S.No	Variables	Mean	SD	Mean difference
1	Schizophrenia	46.68	12.03	13.40
2	Mania	60.08	12.28	

Table 4: The mean score of quality of life of care givers of patients with schizophrenia was 46.68. The score of quality of life of care givers of patients with mania was 60.08. The mean difference was 13.40 and it was inferred that the quality of life of schizophrenia care givers was low comparing to mania care givers.

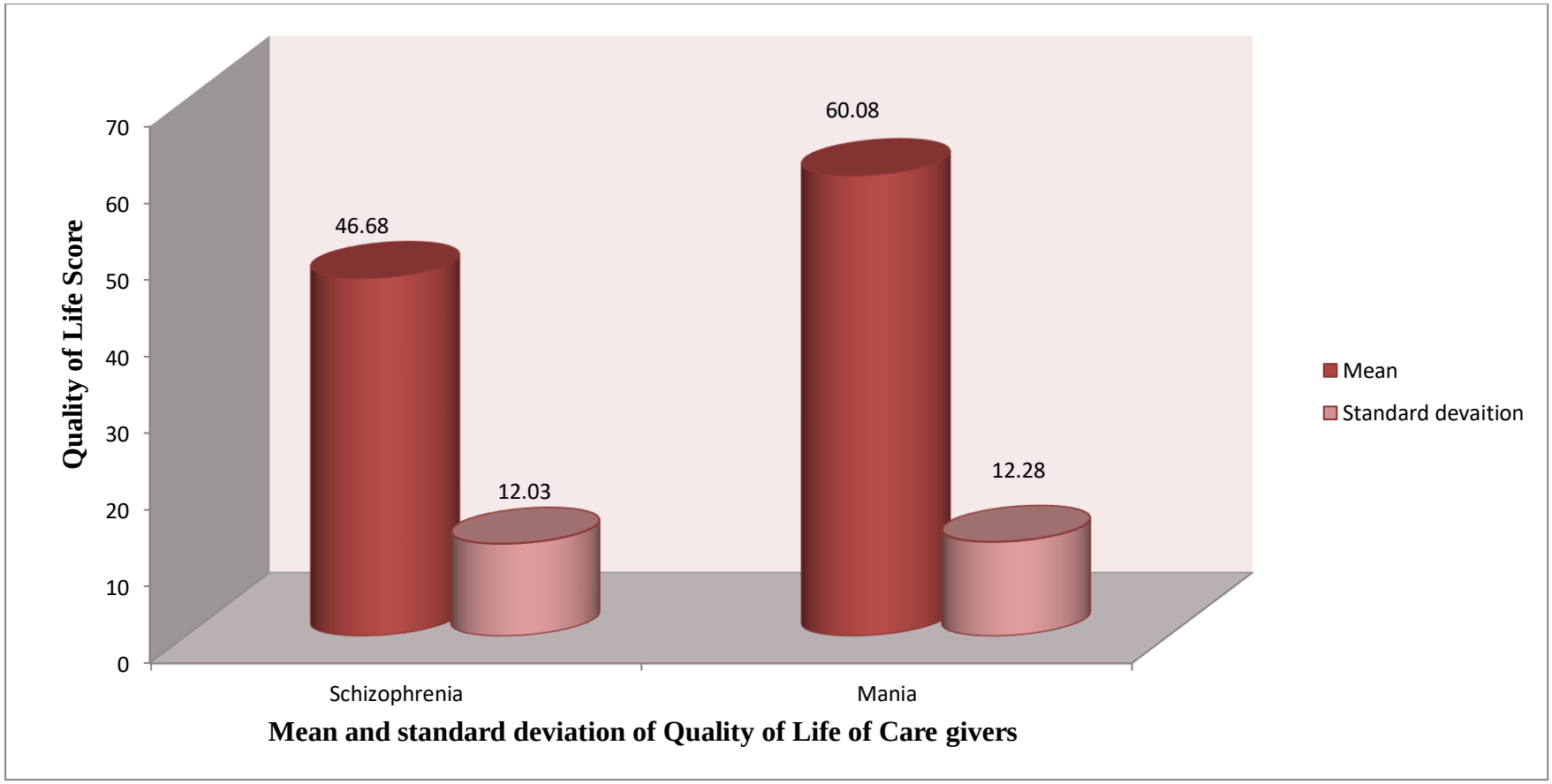

Fig 3: Mean and Standard deviation of Quality of life among care givers of patients with schizophrenia and mania

SECTION-C

Table 5: Data on association between the Quality of Life among care givers of patients with schizophrenia and their selected demographic variables

n=25

S.No	Demographic variables	Level of Quality of Life			χ^2	Table Value 0.05 level of significant
		Low	Average	High		
	Age					
1	a) 30 – 40 years	4	3	0	5.078	4df
	b) 41 – 50 years	4	2	1	**NS**	9.49
	c) 51 – 60 years	2	8	1		
	Gender					
2	a) Male	6	4	0	3.44	2df
	b) Female	4	9	2	**NS**	5.99
	Religion					
3	a) Hindu	4	8	1	2.86	4df
	b) Christian	3	4	1	**NS**	9.49
	c) Muslim	3	1	0		
	d) Others	0	0	0		

NS: Not significant

(contd..)

n=25

S.No	Demographic variables	Level of Quality of Life			χ^2	Table Value 0.05 level of significance
		Low	Average	High		
4	**Education**					
	a) Illiterate	3	2	0	6.11	6df
	b) Only school education	2	6	0	**NS**	12.59
	c) Diploma / degree	2	4	1		
	d) Professional education	3	1	1		
5	**Occupation**					
	a) Un employment	4	6	0	2.20	6df
	b) Private company	3	3	1	**NS**	12.59
	c) Government office	1	1	1		
	d) Business	2	3	0		
6	**Type of family**					
	a) Nuclear	7	10	1	3.91	2df
	b) Joint	3	3	1	**NS**	5.99
7	**Monthly Income**					
	a) Up to Rs. 5000	5	5	0	3.91	4df
	b) Rs. 5001 – Rs.10,000	3	7	1	**NS**	9.49
	c) Above Rs. 10,000	2	1	1		

NS: Not significant

(contd..)

n=25

S.No	Demographic variables	Level of Quality of Life			χ^2	Table Value 0.05 level significance
		Low	Average	High		
8	**Marital status**					
	a) Single	3	2	1		
	b) Married	4	7	1	2.15	df
	c) Widow	2	2	0	**NS**	12.59
	d) Separated / divorced	1	2	0		
9	**Relationship of the patient**					
	a) Parent	1	3	1		
	b) Spouse	3	1	1	5.72	6df
	c) Children	3	6	0	**NS**	12.59
	d) Sibling	3	3	0		
10	**Residency**					
	a) Urban	5	6	1	0.06	2df
	b) Rural	5	7	1	**NS**	5.99

NS: Not significant

Table 5: reveals that there is no significant association between age, gender, religion, education, occupation, type of family, monthly income, marital status, relationship of the patient, residency and their Quality of life.

Table 6: Data on association between the Quality of Life among care givers of patients with schizophrenia and their selected clinical variables

n=25

S.No	Clinical variables	Level of Quality of Life			χ^2	Table Value
		Low	Average	High		
1	**Duration of illness**					
	a) 1 year	1	3	1	2.66	4 df
	b) 1-3 year	5	7	1	**NS**	9.49
	c) Above 3 years	4	3	0		
2	**No of hospitalization**					
	a) First time	1	3	1	2.56	4df
	b) Second time	4	5	1	**NS**	9.49
	c) More than three time	5	5	0		
3	**Types of admission**					
	a) Voluntary	4	7	2	2.45	2df
	b) Involuntary	6	6	0	**NS**	5.99
4	**Availability of support system**					
	a) Family	7	7	2	4.07	4 df
	b) Friends	3	3	0	**NS**	9.49
	c) Society	0	3	0		

NS: Not significant

Table 6: reveals that there is no significant association between Duration of illness, No of hospitalization, Types of admission, Availability of support system and their Quality of life.

Table 7: Data on association between the Quality of Life among care givers of patients with mania and their selected demographic variables

n=25

S.No	Demographic variables	Level of Quality of Life			χ^2	Table Value 0.05 level of significant
		Low	Average	High		
1	**Age**					
	a) 30 – 40 years	1	4	1	2.86	4 df
	b) 41 – 50 years	1	5	2	**NS**	9.49
	c) 51 – 60 years	0	6	5		
2	**Gender**					
	a) Male	2	7	3	2.52	2 df
	b) Female	0	8	5	**NS**	5.99
3	**Religion**					
	a) Hindu	1	8	3		
	b) Christian	0	4	3	1.7	4 df
	c) Muslim	1	3	2	**NS**	9.49
	d) Others	0	0	0		

NS: Not significant

(contd..)

n=25

S.No	Demographic variables	Level of Quality of Life			χ^2	Table Value0.05 level of significant
		low	Average	High		
4	**Education**					
	a) Illiterate	1	2	1		
	b) Only school education	1	6	2	3.02	6 df
	c) Diploma / degree	0	4	3	**NS**	12.59
	d) Professional education	0	3	2		
5	**Occupation**					
	a) Un employment	0	7	2		
	b) Private company	1	3	2	3.90	6df
	c) Government office	1	1	2	**NS**	12.59
	d) Business	0	4	2		
6	**Type of family**					
	a) Nuclear	2	11	4	2.94	2df
	b) Joint	0	4	4	**NS**	5.99
7	**Monthly Income**					
	a) Up to Rs. 5000	2	6	2	5.18	4df
	b) Rs. 5001 – Rs.10,000	0	7	3	**NS**	9.49
	c) Above Rs. 10,000	0	2	3		

NS: Not significant

(contd..)

S.No	Demographic variables	Level of Quality of Life			χ^2	Table Value 0.05 level of significant
		Low	Average	High		
8	**Marital status**					
	a) Single	0	4	3	8.52	6 df
	b) Married	0	8	4	**NS**	12.59
	c) Widow	1	2	1		
	d) Separated / divorced	1	1	0		
9	**Relationship of the patient**					
	a) Parent	0	2	2		
	b) Spouse	0	3	2	2.85	6df
	c) Children	1	7	2	**NS**	12.59
	d) Sibling	1	3	2		
10	**Residency**					
	a) Urban	0	8	3	2.24	2 df
	b) Rural	2	7	5	**NS**	5.99

NS: Not significant

Table 7: reveals that there is no significant association between age, gender, religion, education, occupation, type of family, monthly income, marital status, relationship of the patient, residency and their Quality of life.

Table 8: Data on association between the Quality of Life among care givers of patients with mania and their selected clinical variables

n=25

S.No	Clinical variables	Level of Quality of Life			χ^2	Table Value 0.05 level of significant
		Low	Average	High		
1	**Duration of illness**					
	a) 1 year	0	3	3	1.63	4 df
	b) 1-3 year	1	7	3	**NS**	9.49
	c) Above 3 years	1	3	2		
2	**No of hospitalization**					
	a) First time	0	3	3	4.84	4 df
	b) Second time	0	7	3	**NS**	9.49
	c) More than three time	2	5	2		
3	**Types of admission**					
	a) Voluntary	0	9	5	2.92	2 df
	b) Involuntary	2	6	3	**NS**	5.99
4	**Availability of support system**	1	10	4	3.51	4 df
	a) Family	1	3	3	**NS**	9.49
	b) Friends	0	2	1		
	c) Society					

NS: Not Significant

Table 8: reveals that there is no significant association between Duration of illness, No of hospitalization, Types of admission, Availability of support system and their Quality of life.

CHAPTER-V

DISCUSSION

The purpose of the study was to assess the quality of life among care givers of patients with schizophrenia and mania in selected hospital at Tirunelveli. The study was conducted by using Non experimental Descriptive comparative design among 25 schizophrenia patients care givers and 25 mania patients care givers in selected hospital. The demographic data were collected by the structured self administered questionnaire, Modified WHO Adult quality of life care givers questionnaire scale was used to assess the quality of life of care givers of patients with schizophrenia and mania.

Objectives of the study were

- To assess the quality of life among care givers of patients with schizophrenia and mania.
- To compare the quality of life among care givers of patients with schizophrenia and mania.
- To find out the association between quality of life among care givers of patients with schizophrenia and mania with selected demographic and clinical variables.

1. **To assess the quality of life among care givers of patients with schizophrenia and mania**

The result shows that among care givers of schizophrenia the level of Quality of Life, 10 (40%) had low level of Quality of Life, 13 (52%) had average level of Quality of Life and 2 (8%) has high level of Quality of Life. Among care givers of mania the level of Quality of Life, 2 (8%) had low level of Quality of Life, 15 (60%) had average level of Quality of Life and 8 (32%) has high level of Quality of Life.

Alex (2008)conducted a comparative study was conducted among 50 care givers of both schizophrenia and mania and they reported schizophrenia care givers (68%) are facing more stress than mania care givers (32%).

2. **To compare the quality of life among care givers of patients with schizophrenia and mania**

The result shows that the mean and standard deviation score of quality of life of care givers of patients with schizophrenia was 46.68± 12.03. The mean and standard deviation score of quality of life of care givers of patients with mania was 60.08± 12.28. The mean difference (13.40) was statistically high and significant.

Senbagam (2007) The results of the study shows that more than 80% of the primary care givers of mentally ill patients are experiencing a low level of quality of life with a standard deviation of 58.69 and the mean difference was statistically high and significant associated with emotional disturbance, a

perceived health changes, isolation and disappointment in relation to caring the patients.

3. **To find out the association between quality of life among care givers of patients with schizophrenia and mania with selected demographic and clinical variables.**

The result reveals that there is no association between the care givers of schizophrenia and mania patients with their demographic variables such as age, gender, religion, education, occupation, type of family, monthly income, marital status, relationship of the patient, residency and their Quality of life.

There is no significant association between the care givers of schizophrenia and mania patients with their clinical variables such as duration of illness, No of hospitalization, types of admission, Availability of support system and their Quality of life.

CHAPTER-VI

SUMMARY, FINDINGS, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

Summary of the study

The aim of the study was to assess the quality of life among care givers of patients with schizophrenia and mania in selected hospital at Tirunelveli.

The study was comparative in nature based on the inclusion criteria selected 25 schizophrenia patients caregivers and 25 mania patients care givers were selected by using purposive sampling technique and Modified WHO Adult quality of life of care givers questionnaire is used to assess the quality of life.

Study was based on Quality of life. It provides a comprehensive systemic frame work for evaluate the quality of life among care givers of patients with schizophrenia and mania. Descriptive and Inferential statistical test were used to report the findings.

Main findings of the study:

Description of the Demographic data of the study,

Among the care givers of 25 schizophrenia patients,11(44%) belong to age group 51-60years,15(60%) were females,13(52%) were Hindus, 8(32%) had

studied in school education,10(40%) Unemployment,18(72%) were Nuclear family, 11(44%) Income was Rs.5001-10,000,12(48%) were Married,9(36%) Were Children, 13(52%) living in rural area.

Among the care givers of 25 mania patients, 11(44%) belong to age group 51-60 Years, 13(52%) were females, 12(48%) were Hindus,9(36%) had studied in school education, 9(36%) Unemployment,17(68%)were Nuclear family, 10(40%) And 10(40%) Income was UptoRs5000 and Rs.5001-10.000, 12(48%) were Married,9(36%) were Children, 14(56%) living in rural area.

Description of Clinical data of the study,

Among the care givers of 25 schizophrenia patients, 13(52%) had illness for 1-3Years, 10(40%) and were hospitalized for second time and 10(40%) were hospitalized for more than three times, 13(52%) with voluntary admission, 16(64%) persons support system was family among the care givers of 25 mania patients, 11(44%) had illness for 1-3Years, 10(40%) were hospitalized for Second time, 14(56%) with Voluntary admission, 15(60%) persons support system was family.

Frequency and Percentage distribution of level of Quality of Life among care givers of patients with mania and schizophrenia10(40%) care givers of schizophrenia patients and only 2(8%) care givers of mania patients had reported Low Quality of Life. It was evident that 13(52%)

care givers of schizophrenia patients and only 15(60%) care givers of mania patients had reported Average Quality of Life 2(8%) care givers of schizophrenia patients and only 8(32%) care givers of mania patients had reported High Quality of Life.

Conclusion:

The main conclusion drawn from this present study was that the quality of life among schizophrenia care givers was low comparing to the mania care givers. As the stress level of schizophrenia patients care givers were high the researcher provided counseling and distributed the pamphlets regarding stress management techniques to relieve their stress level and improve their quality of life.

Implications:

Nursing implication usually includes specific suggestions for Nursing Education, Nursing Administration and Nursing Research.

i) Nursing administration

- The nurse administrator should take initiative in organizing continuing nursing education programme regarding the quality of life among care givers and formulate policies, protocols in increasing the quality of life of care givers of patients with schizophrenia and mania.

- Nurse administrators can inculcate to staffs and subordinates through inservice education on care of stressed people.

ii) Nursing education

- The practical knowledge of the Nurse depends upon the education they receive. So the Nursing Education should prepare the Nurses to realize their responsibility as 'Nurse Educator'

- Sufficient experience to improve practical skill must be included in Nursing Education programme.

- The curriculum should prepare the students to render their health services in various settings like community, hospitals, industry and other areas.

iii) Nursing research

- Most of the research efforts in assessing the Quality of life of care givers have been from western countries and so there is a need to conduct further research studies in developing countries like India.

- The findings of the present study help to expand the study in different fields.

Recommendations:

- The study can be replicated with large sample size.

- The comparative study can be conducted between Bipolar affective disorder and Obsessive compulsive disorder.

- The same study can be conducted as longitudinal study.

- A similar study can be carried out in community settings also.

- An interventional study using Guided imagery and other relaxation technique can be carried out among care events of mentally ill patients.

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ANNEXURE-A

Letter seeking expert's opinion for content validity

From,

Ms.KrishnaLeela. S,

M.Sc (N) IInd Year,

Nehru Nursing College,

Vallioor.

To,

Through

The Principal,

Nehru Nursing College,

Vallioor.

Respected Madam / Sir

Sub: Requesting opinion and suggestion for establishing content validity of Research Tool.

I would like to bring to your kind consideration that as a part of my M.SC (N) II Year curriculum, I have selected the below mentioned topic for dissertation to be submitted to the Tamilnadu Dr. MGR Medical University, Chennai as a partial fulfillment of the degree of Master Science in Nursing. My Research topic is **"A comparative study to assess the quality of life among caregivers of patients with schizophrenia and mania in selected hospital at Tirunelveli"** With regard I kindly request you to validate my tool for its appropriateness and relevancy. Here with I am enclosing the need for the study, statement of the problem, objectives, demographic variables, clinical variables, Adult quality of life caregivers questionnaire. I would be highly obliged and remain thankful for great help if you validate and suggest your opinion.

Place Thanking you Yours Sincerely,

Date **Krishna Leela.S**

ANNEXURE - B

List of experts to validate the tool

Dr. C. Paneerselvan, M.B.B.S, M.D,
Psychiatrist,
Sneka Mind Care Centre,
Thirunelveli.

Mrs. Mary Jeya, M.Sc (N),
Assistant Professor,
Dr.Kumaraswami Health Centre, College of Nursing,
Kottaram.

Mr.C.SelginLeons, M.Sc (N),
Lecturer,
Sri.K.Ramachandra Naidu College of Nursing,
Tirunelveli.

Mrs.Caroline, M.Sc (N),
Assistant Professor,
Catherin Booth College of Nursing,
Nagercoil.

Mr.Vinifred ,M.Sc (N),
Assistant Professor,
Annammal College of Nursing,
Kuzhithurai.

ANNEXURE – C

NEHRU NURSING COLLEGE

G.O.(MS) NO. 486 HEALTH DATED ON 27.8.98

THE TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY PROC. NO.:18677/AFFLN.II(1)/99 Dated on 28.9.2000

APPROVED BY TAMIL NADU NURSES AND MIDWIVES COUNCIL AND INDIAN NURSING COUNCIL

NEHRU NAGAR, POST BOX NO. 3,
TIRUCHENDUR ROAD, ***VALLIOOR - 627 117.***
TIRUNELVELI DIST, TAMILNADU.

Email : nehrunursingcollege@gmail.com
Tel : 04637 - 221460, 222126
Teli Fax : 04637 - 221460

Date : 01/02/2016

Your Ref :

Our Ref : NNC/Thesis/08

To
The Medical Director,
Sneka Mind Care Center,
Thirunelveli.

Respected sir,

Sub: Requisition for conducting the research study- Krishna Leela.S, M.Sc (N) II year student.

As a part of the curriculum requirement under the Tamilnadu Dr. M.G.R. Medical University, our M.Sc (N) II year student Krishna Leela.S would like to conduct a research during his course of study. She has selected the following topic for research.

"A comparative study to assess the quality of life among caregiver of patients with schizophrenia and mania".

As we would like to conduct the research in Sneka Mind Care Center, we kindly request you to grant his permission to conduct the study in your esteemed hospital. I assure you that he will abide by the policies of the hospital and not cause any disturbance to the routine client care. Kindly consider and grant permission for the above mentioned study purpose during the clinical posting period February 2016.

Thanking you,

With kind regards,

NEHRU NURSING COLLEGE

Principal

Dr. C. PANNEER SELVAN M.D. (Psych): MRMC
Consultant Psychiatris:
Sneka Mind Care Centre
12, South Bye Pass R[illegible].
TIRUNELVELI - 627 00[illegible].

ANNEXURE-D

TOOL FOR DATA COLLECTION

Section-A demographic variables of care givers

1.Age (in years)

a. 30-40 years [ ]

b. 41-50 years [ ]

c. 51-60 years [ ]

2. Gender

a. Male [ ]

b. Female [ ]

3. Religion

a. Hindu [ ]

b. Christian [ ]

c. Muslin [ ]

d. Others [ ]

4. Education

a. Illiterate [ ]

b. Only school education [ ]

c. Diploma/Degree education [ ]

d. Professional education [ ]

5. Occupation

a. Unemployed [ ]

b. Private company [ ]

c. Government office [ ]

d. Business [ ]

6. Type of the family

a. Nuclear [ ]

b. Joint [ ]

7. Monthly income (in rupees)

a. Upto-Rs.5000 [ ]

b. Rs.5001-Rs.10,000 [ ]

c. Above Rs.10,000 [ ]

8. Marital status

a. Single [ ]

b. Married [ ]

c. Widow [ ]

d. Separated/Divorced [ ]

9. Relationship of the patient

a. Parent [ ]

b. Spouse [ ]

c. Children [ ]

d. Siblings [ ]

10. Residency

a. Urban [ ]

b. Rural [ ]

b)clinical variables of patient

1.Duration of the illness

a. 1year [ ]

b. 1-3years [ ]

c. Above 3 years [ ]

2. Number of hospitalization

a. First time [ ]

b. Second time [ ]

c. More than 3 times [ ]

3. Type of admission

a. Voluntary admission [ ]

b. Involuntary admission [ ]

4. Availability of support system

a. Family [ ]

b. Friends [ ]

c. Society [ ]

MODIFIED WHO ADULT QUALITY OF LIFE OF CARE

GIVERS ASSESSMENT SCALE

Sl. No	Items	Never 1	Rarely 2	Some Times 3	Always 4
	PHYSICAL DOMAIN:				
1	Do you have good energy for day to day's life activities?				
2	Do you have good appetite?				
3	Do you enjoy eating?				
4	Do you have good satisfaction with your sleep?				
5	Do you feel energetic for the full day?				
6	Are you able to concentrate on your day to day activities?				
	PSYCHOLOGICAL DOMAIN:				
7	Do you have good satisfaction with your care giver role?				
8	Does sharing your problem with others make you feel better?				
9	Do you feel you are providing better care to your relative to improve his or her well being?				

10	Does your society shows positive attitudes towards your relatives illness?				
11	How often you feel happy?				
12	Do you recall past happiest moments?				
13	Do you have good satisfaction with your personal life?				
14	Do you feel peace with your day to day life?				
15	How safe do you feel in your daily life?				
16	How satisfied are you with the health care services?				
	SOCIAL DOMAIN :				
17	Do you enjoy talking with co - workers and your friends?				
18	Do you have enough support from your support system?				
19	Do you maintain good relationship with neighbours and relatives?				
20	Do you enjoy your leisure time?				
21	Are you able to relax for some time during day time?				
22	Do you regularly help others?				

SCORING:

- QUALITY OF LIFE IS LOW = 22-44
- QUALITY OF LIFE IS AVERAGE = 45-66
- QUALITY OF LIFE IS HIGH = 67-88

PAMPHLET ON STRESS MANAGEMENT TECHNIQUES

- **RELAXATION TECHNIQUES:**

  - **Teaching deep breathing exercise:**

✓ Sit up straight ,Do not arch your back.

✓ Put one hand on your abdomen.

✓ Slowly breath in and breath out 2 times.

✓ Gently breath in (1to5) and feel that abdomen raise slowly with your hand.

✓ Breath out (1to5) slowly and completely feeling your abdomen sink.

✓ Pause for a movement and then repeat the cycle of breathing.

- **Guided Imagery:**

With your eyes closed, take a moment to create, in your mind's eye, an ideal spot for relaxation. You can make it any place- real or imagined. Perhaps it is your favorite room, a beautiful meadow, an ocean beach, or a floating cloud. See yourself in comfortable clothes, completely relaxed and take a few deep breaths. Once you have created this place in your mind, you can go back there whenever you want an escape from your busy day or a stressful situation.

- **PHYSICAL ACTIVITY:**

Physical activity increases your overall health and sense of well-being. It also has stress-busting benefits like pumping up your endorphins, improving your mood, providing a break from your stressors and increasing self-esteem. Try to walk or do something active for 20 minutes a day. To gain additional benefits

from aerobic and muscle strengthening activities, find a more intense physical activity that you enjoy and do that a few times a week too.

- **SLEEP:**

Good sleep habits reduce stress and help your body recover from stress. Everyone needs a different amount of sleep, however it is recommended to get 7-8 hours of sleep a night. Short naps can also re-energize you and improve your mood. It is suggested that naps not exceed 30 minutes or you may feel groggy.

- **EATING SMART:**

Eating breakfast and eating regularly throughout the day (every 3-5 hours) prepares your body to better cope with stress. Skipping meals should be avoided because it lowers your energy and your ability to focus. Choose more whole and unprocessed foods, and eat a lot of colorful fruits and vegetables to feel your best.